

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-047698

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 128

Primary Registration District No. 5466

Registrar's No. 1850

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

VS 300
Rev. 4/59

10397

2397

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

Registration District No. 128

Primary Registration District No. 5466

Registrar's No. 1850

STATE FILE NUMBER

FILED DEC 30 1963

1. PLACE OF DEATH

a. COUNTY

GREENE

b. CITY (If outside corporate limits, give TOWNSHIP only)

OR TOWN SPRINGFIELD

Length of stay in 1b

80 yrs

c. FULL NAME OF (If NOT in hospital, give location)

HOSPITAL OR INSTITUTION SUNSHINE ACRES

Inside Limits

Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before

a. STATE

MO

b. COUNTY

GREENE

admission)

c. CITY

OR TOWN

SPRINGFIELD R.R.

Inside Limits

Yes ☐ No ☐

d. STREET

ADDRESS

SUNSHINE ACRES

Reside on Farm

Yes ☐ No ☐

3. NAME OF DECEASED

(Type or print)

First

OTIS

Middle

B

Last

MEARS

4. DATE

OF DEATH

Month

DEC

Day

24

Year

1963

5. SEX

MALE

6. COLOR OR RACE

NEGRO

7. Married ☐Never Married ☐Widowed ☒Divorced ☐

8. DATE OF BIRTH

Aug 6 1866

9. AGE (last birthday)

97

IF UNDER 1 YEAR

Months

IF UNDER 24 HR

Hours

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

LABORER

10b. KIND OF BUSINESS OR INDUSTRY

COMMON

11. BIRTHPLACE (City and state or country)

OSAGE MO

12. CITIZEN OF WHAT COUNTRY

U.S.A

13a. FATHER'S NAME

JAMES MEARS

13b. MOTHER'S MAIDEN NAME

UNKNOWN

14. NAME OF HUSBAND OR WIFE

NONE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of service)

NO

17. INFORMANT

FLORENCE CAMPBELL

Address

218 N. FRANKLIN

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cerebrovascular Disease

INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT

SUICIDE

HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY

Hour a.m. p.m.

Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from Dec. 17, 1963 to 12/24/63 and last saw him alive on 12/18/63

Death occurred at 6:30 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

Leman W. Brown M.D.

22b. ADDRESS

311 1/2 College

22c. DATE SIGNED

12/24/63

23a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

23b. DATE

12-27-63

23c. NAME OF CEMETERY OR CREMATORY

LINCOLN

23d. LOCATION (City, town, or county)

SPRINGFIELD MO

24. FUNERAL DIRECTOR

Herbert Smith

ADDRESS

602 N. Jefferson

25. DATE RECD. BY LOCAL REG.

12-27-63

26. REGISTRAR'S SIGNATURE

Bernie Tiedtke

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No: _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Herbert V. Smith

Licensed Embalmer No.

4286

P. O. Address

Springfield Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.